CONNECTICUT OFFENDER REENTRY WORKPLAN

1. Determine Problems to be Addressed

Introduction. The CT Department of Mental Health and Addiction Services (DMHAS) has identified a distinct group of serious offenders that is at extremely high risk of continued involvement with the adult criminal justice system, where it is likely to languish in tax consumptive dependence, including lifetime cycles of incarceration, addiction, mental illness, unemployment, and homelessness. Serious and violent young offenders, ages 18-34 with significant mental health and co-occurring substance use disorders, have been found to be inadequately served by the state's current treatment and service systems. Between 1985 and 1998 the number of inmates in jails across the nation increased by 131 percent. A similar trend is apparent within state and federal prisons (Lamberti et al., 2001). Within this rapidly growing prison population, persons suffering from severe mental illness are over-represented. The prevalence and incidence of co-occurring mental and substance use disorders among serious young adult offenders have been shown to be significant predictors of recidivism and re-arrest (Solomon and Drake, 1995). Factors associated with co-morbidity among young adult offenders, such as homelessness, unemployment, and risk of violence, are indicative of the need for an effective, comprehensive and integrative treatment and service delivery approach.

The target population identified in this proposal as serious and violent young mentally ill adults in the correctional system with co-morbid substance use disorders is particularly vulnerable to arrest and recidivism. The multiple problems that this population faces cannot be adequately addressed by traditional community-based services. Factors identified as related to poor treatment outcomes include a history of resistance to treatment, non-compliance with psychoactive medications, and refusal of appropriate housing placements. Researchers have indicated the need for service models that improve the liaisons between the criminal justice system and the treatment systems. In addition, an enhanced integration between the mental health and substance abuse treatment services has been advocated as the most efficacious approach to the provision of services (Rock, 2001).

Research has demonstrated that the prevalence of severe mental disorders within correctional populations is significantly higher than in the general population (Teplin, 1990; Chiles, Von Cleve, Jemelka, and Trupin, 1990). Data on the co-occurrence of a substance use disorder among the correctional population with severe mental disorders demonstrates a significantly high rate as compared to the general population. The rate of co-disorders among correctional populations has been reported to be as high as 72% of inmates with a current serious illness, with lifetime co-disorder rates as high as 94% (Abram and Teplin, 1991). In one study, all offenders with a diagnosis of schizophrenia, schizophreniform disorder, or mania were given a diagnosis of drug or alcohol abuse or dependence (Chiles, Jemelka, and Trupin, 1990).

In one study, 43% of the defendants with mental health disorders were homeless at the time of the crime for which they were arrested. The rate of homelessness was 21 times higher in the overall sample of defendants than in the overall population of mentally ill persons in the city in which the study was conducted (Lamb, et al, 1998). In another study, 30% of the participants reported that they would be homeless on release (Hartwell and Orr, 1999). Interestingly, recidivism has been found to be significantly associated with residential instability (Lamberti, et al., 2001). Another important factor in recidivism is the high rate of unemployment demonstrated to be associated with this population. Studies have shown that between 80 and 90% of persons within this population are unemployed (Lamb and Weinberger, 1998). Further, persons of color are over-represented within this population; therefore the relevance of cultural issues in preventing incarceration of this population should be given serious attention. (Lamberti, et al., 2001). Thus, offenders with co-occurring disorders need vocational assistance in addition to case management, and all staff must be carefully trained in cultural competence.

To address these issues, DMHAS, in a multi-state agency collaborative with the Department of Correction (DOC), the Judicial Branch's Court Support Services Division-Probation (Probation), Board of Parole (Parole), and the CT Employment and Training Commission-State Workforce Investment Board (WIB), seeks to implement a model program to ensure the continuity of care for individuals released from the state's correctional facilities in a manner that is cognizant of public safety, encourages community reintegration, employment and housing stability, and decreases recidivism. This project will focus on serious young offenders with significant mental health and co-occurring substance use disorders returning to the Hartford, New Haven, and Bridgeport communities.

The Population. The Department of Correction (DOC), as of March 2001, reports a total prison inmate population of 17,458, comprised of 46% of African Origin, 27% White, and 26% Latino populations. DOC estimates that 85% of its inmates have a substance use disorder, based on evaluations of inmates at time of incarceration. A recent CT legislative report on prison overcrowding, issued by the Program Review and Investigations Committee, (PR&I), estimates that about 12% of those under DOC custody need mental health treatment. This estimate is consistent with national studies showing that over 6% of male inmates have a severe mental disorder and the rate of severe mental illness among women prisoners is about 15% (Teplin et al., 1996). The number of inmates wanting mental health care is about 16%, according to recent data from the U.S. Department of Justice (1999). Due to CT's current prison overcrowding, it is anticipated that community-based substance abuse and mental health treatment capacity for offender populations will continue become increasingly limited.

The total offender population supervised in the community includes approximately 55,070 on probation, almost 2,010 on parole, and another 1,300 in the community under DOC supervision (i.e., transitional supervision, furlough, and halfway house release). The **Judicial Branch's Court Support Services Division (CSSD)-Probation** provides intake, assessment and supervision services for court-involved individuals. Of the 55,070

individuals currently under CSSD-probation supervision, 78% are males and 22% females and the ethnic composition is 51% White; 28% African Origin; and 19% Latinos. CSSD estimates that nearly 80% of CSSD clients (pre-trial and sentenced) have a diagnosable behavioral health disorder. CSSD has also estimated that a significant number of these clients are homeless or in need of housing assistance. The demographics of the 2,010 individuals under **Board of Parole** supervision includes: 92% males, 8% females, 49% of African Origin, 28% Latinos, and 23% White. **Probation** and **Parole** are both responsible for monitoring the conditions of probation and parole in order to hold offenders accountable and to promote public safety and offender rehabilitation. Of the 199 inmates referred to DMHAS' Forensic Unit in State Fiscal Year 2001, 93% were males; 7% were females; 56% were of African Origin; 26% White; and 19% Latino. Over 75% of these individuals had a significant mental illness and co-occurring substance use disorder. Approximately 99% of these individuals' committed serious and/or violent offenders, including sexual assault, assault robbery, possession and sale of illicit substances, and manslaughter. Additionally, over 38% of these individuals were homeless at the time of referral.

State Data. As part of its ongoing assessment of treatment need, funded by the federal Center for Substance Abuse Treatment (CSAT), DMHAS commissioned Yale University to interview adult arrestees (Schottenfeld, 1996). The Substance Abuse Need for Treatment among Arrestees study was conducted in two of the state's detention centers located in Hartford and Bridgeport. The interview consisted of questions from both the Drug Use Forecasting and the Structured Clinical Interview for DSM-IV. Approximately six in ten arrestees interviewed (57% of men and 61% of women) were dependent on one or more substances. Of the arrestees interviewed 33% reported cocaine dependence, 18% reported heroin dependence, 10% reported marijuana dependence, and 31% reported alcohol dependence. The vast majority (91%) of heroin dependent males reported a current need for treatment, but very few (10%) were currently in treatment. A significant proportion of heroin dependent male arrestees (32%) had never received any substance abuse treatment, including detoxification. The majority (52%) of substance dependent females reported a current need for treatment, but very few (19%) were currently in treatment. Reported need for treatment was also extremely high among women dependent on cocaine (86%) or heroin (82%).

Analysis of Eligible Offenders to be Served. As of September 2001, DOC reported that a total of 2,140 inmates have a mental health score of 3-5 and a co-occurring substance abuse score of 3-5. (Please see *Step Three - Select Target Population* for a more detailed explanation of mental health and substance abuse scores). Within this year, it is anticipated that 356 of these individuals will be released to the Hartford, New Haven or Bridgeport communities, illustrated in Table 2. Of these individuals, approximately 30-35%, with MH 3-4 and SA 3-4, will be deemed eligible for *CORP*. Individuals with MH-5 will be referred to DMHAS' Whiting Forensic Division. Individuals with lower MH and SA scores will be referred to existing community programs.

Barriers to Service/An Objective Look at the Current System. Not all needed services for adults released from the state's correctional facilities with co-occurring disorders are available in the targeted areas, and scrutiny of the mental health, substance abuse, employment, and housing systems demonstrates service gaps and needs. As part of the planning process for this model, DMHAS convened various agencies handling this population—DOC, Probation, Parole, WIB, and mental health, substance abuse, employment, and housing providers to study the existing service continuum. Together the stakeholders identified that this target population was: 1) receiving services that did not fit their cultural needs; 2) not engaged and hard to reach once released into the community; 3) in need of nontraditional options in pre-release planning and easier access to services and entitlements prior to release; 4) lacking continuity of care from prison to community; and 5) in need of intensive case management services to connect with services for basic needs such as housing, employment, and applying for benefits prior to release. The stakeholders agreed that strengthening an interagency (DMHAS, DOC, Probation, Parole, WIB) and an inter-community collaboration (Local Mental Health Authorities-LMHAs in Hartford, New Haven, and Bridgeport) would increase the quality and effectiveness of the proposed program. The Connecticut Offender Reentry Program (*CORP),* a culturally appropriate system of institution and community-based linkages and supports, was conceptualized.

Connecticut's substance abuse, mental health, criminal justice, employment, and housing systems are decentralized. As a result, high-risk individuals are falling through the cracks without appropriate assessment for substance abuse, mental health, employment, and housing services prior to release. Recognizing the fragmentation in the current system of care, this initiative allows CT to implement and establish a coordinated and community-based initiative to build sustained recovery for adults with co-occurring disorders, released from the state's correctional facilities. *CORP* will bring DMHAS, DOC, Probation, Parole, and WIB, key substance abuse, mental health, employment, and housing providers within the Hartford, New Haven, and Bridgeport communities, and consumer and advocacy groups together. Jointly, we can combine resources to create innovative solutions to replicate in other cities in CT.

Essential to the successful implementation of the *CORP* are: 1) Increased availability of integrated substance abuse and mental health treatment services; 2) Cultural competency and gender specificity in the delivery of treatment; 3) Strengthened state and local partnerships responsive to the multiple needs of the target population; 4) Effective engagement, retention, and coordination of service, advocating for system improvement, and providing a continuum of pre-release, release, aftercare and recovery services; and 5) More effective motivational counseling to change behavior by building and enhancing skills.

Additionally, underlying values of the proposed *CORP* include*:* 1) Shared belief that *recovery* from substance abuse and mental illness is possible; 2) Importance of *stable housing and employment* in achieving sobriety, maintaining recovery, and in personal development; 3) Priority of *individuals' goals* in determining their pathway to recovery,

stability, and self-sufficiency; 4) Value of *cultural competence and gender-sensitivity* in designing and delivering services; 5) Importance of *hope and empowerment* in changing the course of individuals' lives; 6) Value of the *community's involvement* in delivering new programs that promotes recovery; and 7) Priority of ensuring *victims' rights and public safety.*

Connecticut Offender Reentry Workplan

2. Determine Goals and Objectives

The primary goal of the Connecticut Offender Reentry Program (*CORP)* is to expand culturally appropriate intensive case management, integrated mental health and substance abuse treatment services, and strengthen linkages for men and women released from the state's correction institutions who have significant mental health and co-occurring

substance use disorders, with emphasis on serious and violent offenders who are homeless or at imminent risk of homelessness upon release. Through this state agency and local community partners collaborative, the target population will be successfully reintegrated within their communities in a manner that focuses on intensive collaboration with community criminal justice supervision entities. The *CORP* program will also have a lasting effect on the integration of services by facilitating the identification of an appropriate service strategy that protects public safety and which can be replicated throughout the state and/or nationally.

Goal A. Building on the existing DMHAS/DOC pre-release planning infrastructure, to enhance the referral network and service coordination for men and women, ages 18-34, with significant mental health disorders and co-occurring substance use disorder, up to one year prior to release from the state's correction institutions.

Objective A.1. To provide an efficient screening tool to correctional facilities to facilitate identification and referral of eligible clients.

Objective A.2. Once clients are referred to *CORP***,** to conduct preliminary intake and screening of a minimum of 300 individuals (annually) and refer all interested individuals (minimum of 150 individuals) for needed services.

Objective A.3. For the 150 individuals eligible for this program, to determine which are most appropriately served through the newly developed intensive case management and integrated treatment services of *CORP***,** and who may be more appropriately served by other programs (e.g., already clients of those programs). We estimate that 120 will be in the former and 30 in the latter.

The goals and objectives listed in the DMHAS program proposal will compliment the goal for the prevention of reoffending by providing for the establishment of a collaborative planning process with all stakeholders that include the entities responsible for criminal justice supervision. The screening and assessment process will assist in identifying those most appropriate. The utilization of motivational enhancement therapy (MET model) while incarcerated and in the community, will further support program compliance.

Goal B. Engage persons in the target population in case management to help connect them to integrated behavioral health treatment and employment, housing, and entitlements and facilitate their exit from the correctional facility.

Objective B.1. To provide intensive case management services to 120 persons, including assistance with developing a comprehensive offender reentry plan for integrated mental health and substance abuse treatment, criminal justice supervision, employment, housing

entitlements, living skills, education, and related service referrals, up to one year prior to release. 100% of *CORP* participants will have a comprehensive reentry plan developed in conjunction with the DMHAS partners, that integrates services across the key institution and community-based providers.

Objective B.2. To improve the engagement and retention of the targeted population in treatment by offering services that are based on Motivational Enhancement Therapy (MET) approach, trauma sensitivity, and cultural competence and that are focused on basic needs. Increased retention and favorable treatment outcomes are anticipated for at least 85% of the 120 individuals annually.

The DMHAS goals enhance the goal of public safety by partnering with the Board of Parole and Office of Adult Probation. Because DMHAS is not a criminal justice entity, supervision and monitoring will be the responsibility of our criminal justice partners with strong collaboration and communication from DMHAS. Both Parole and Probation have the ability to utilize electronic monitoring, when appropriate. Graduated sanctions will also be a component of the discharge and supervision planning.

Goal C. To expand the capacity for case management, integrated mental health and substance abuse treatment, and housing and employment services for men and women released from the state's correctional facilities with co-occurring disorders who are returning to the targeted cities.

Objective C.1. To increase case management, integrated mental health and substance abuse treatment, and housing and employment service capacity to a minimum of 120 (annually) individuals with significant mental health and co-occurring substance use disorders released in the Hartford, New Haven, and Bridgeport areas.

Objective C.2. To improve substance abuse and mental health treatment outcomes of the target population by offering treatment based on the New Hampshire stage-wise integrated substance abuse and mental health treatment model, which is based on Motivational Enhancement Therapy (MET) with additional components.

Objective C.3. To improve the engagement and retention of the targeted population in treatment by offering services that are based on MET, trauma sensitivity, gender sensitivity, and cultural competence and focused on basic needs.

The goal of redeploying and leveraging existing community resources is met by the expansion of the current systems and services offered within the Local Mental Health Authorities. In addition, this initiative expands the existing collaboratives currently underway between the Department of Correction, Parole and Probation.

Goal D. To assist the target population to maintain the effects of substance abuse and mental health treatment by strengthening the necessary employment and housing linkages, community-based, and family supports and aftercare services for a successful reintegration into the community.

Objective D.1. To engage individuals in the pre- and after-care planning by developing a self-identified reintegration plan (offender reentry plan) based on the individuals' needs to assure a sustained recovery.

Objective D.2. To involve a minimum of 100% of individuals in treatment, employment, housing, family (if applicable) and aftercare supports, such as peer support recovery groups, and mentoring programs.

The enhanced services offered through the CORP will aim to build connections with family support systems and offender mentoring support programs in addition to the usual links to community treatment agencies, housing supports and employment opportunities, Additionally, the criminal justice partners can access a broad range of community service options available within their own service system.

Goal E. To establish an infrastructure that ensures the continuity of institution-based to community-based services for the target population, including sustainability plan.

Objective E.1. To develop and implement an integrated service delivery plan, including a practical strategy for sustaining the model program in Hartford, New Haven, and Bridgeport and funding additional programs across the state.

Objective E.2. To ensure that service gaps for this target population are filled by convening a Reentry Steering Committee (RSC) with representatives from DMHAS, DOC, Probation, Parole, WIB, community-based providers, recovery communities, and family members, etc., to oversee development and implementation of the intervention.

The incorporation of key stakeholders in the Steering Committee will foster broad range support as well as investment for the continued sustainability of the program beyond the grant's completion date.

Goal F. To conduct a high quality program evaluation through an academic institution.

Objective F.1. To engage the University of CT, Department of Psychology (DMHAS' Research Division) to conduct an outcome evaluation in coordination with the National Evaluation Study.

Objective F.2. To disseminate findings by producing a written evaluation report for statewide use, and particularly to inform CT's Alcohol and Drug Policy and Mental Health Policy Councils, as part of its annual report to the Governor.

CONNECTICUT OFFENDER REENTRY WORKPLAN

3. Select Target Populations

The target population includes adult men and women, ages 18-34, who have served at least one year in confinement under the Department of Correction (DOC), are returning to either Hartford, Bridgeport, or New Haven, and who have significant mental health and co-occurring substance use disorders, with emphasis on serious and violent offenders. Specifically, the Connecticut Offender Reentry Program (*CORP*) will target individuals assessed by DOC Mental Health and Addiction Services staff with a Mental Health score of 3-4 and co-occurring Substance Abuse score of 3-4 (DOC scores defined below). The validity of the Connecticut Department of Correction's mental health and substance abuse scores are highlighted in a February 2000 report to the Connecticut General Assembly which reads in part…"In Connecticut, approximately 12% of the jail and prison populations are in need of mental health treatment. Based on its jail survey, NAMI estimated the prevalence of serious mental disorders in DOC facilities in 1992 to be 12%. This estimate is remarkably consistent with the results of current DOC assessment ratings. A recent DOC analysis of mental health assessments of 6,128 inmates (a non-random sample of 36% of the population) revealed that 30 (0.5%) scored at the highest level of need; 102 (1.7%) scored at the next highest level, and 596 (9.8%) scored in the moderate need range. Thus, a total of 11.9% of the inmate populations with completed assessments exhibited the need for treatment." Additionally, referrals from DOC to DMHAS for inmates with mental health needs have demonstrated a strong correlation between the DOC score and the eventual psychiatric acuity level as assessed by DMHAS.

Mental Health 3 (MH-3)	Mildly or moderately impaired with a latent or chronic mental illness, including individuals with chronic schizophrenia and bipolar disorder who are compliant with medications and may have periodic psychotic exacerbations requiring hospitalization.
Mental Health 4 (MH-4)	Moderate impairment from a psychiatric condition, mental illness, or a sub-acute or chronic nature, including individuals with chronic schizophrenia, bipolar disorders, and borderline personality disorder.
Mental Health 5 (MH-5)	Severely impaired with an acute psychiatric condition such as major psychosis, affective disorder or major depression or acute anxiety.
Substance Abuse 3 (SA-3)	Serious history of substance abuse and meets three of the following criteria: 1) abused alcohol or other drugs on a regular basis within two years prior to incarceration; 2) medically detoxified for substance abuse at least once; 3) had a least one unsuccessful treatment episode; and 4) substance abuse disrupted at least one major life area.
Substance Abuse 4 (SA-4)	Chronic history of substance abuse and meets three of the following criteria: 1) abused alcohol or other drugs on a habitual basis prior to incarceration; 2) medically detoxified for substances at least twice; 3) had a least one unsuccessful treatment episode; 4) substance abuse disrupted at least two major life areas.

The selection process. As described in other sections of the Workplan document, the target population will be selected through a formal screening process. The Department of Correction will first screen for individuals who have a Mental Health score of 3 or 4 (see below), a Substance Abuse score of 3 or 4, and are scheduled to be returning to one of the geographical target areas after serving at least a year incarcerated. Emphasis will be placed on individuals who are returning to the community with some form of criminal justice supervision.

Utilizing an in-depth assessment tool (see Phase I of the Workplan) individuals will then be screened by a member of the Transition Team to determine who is most appropriately served through the *CORP* and who might be appropriate for other programs. Individuals not meeting the criteria will continue to be eligible for community treatment services through the normal DMHAS referral process. Assessments for those selected to participate will be screened by the Risk Review Team to assist in informing the Offender Reentry Plan (see Phase I).

CORP will give priority to individuals who meet the target population and who are homeless or at imminent risk of becoming homeless upon release. This target population presents unique challenges to our traditional treatment and service systems. We anticipate this target population to have a poor work history marked by short-term jobs and to have limited work skills, but capable of holding individually matched jobs when supported by a vocational coach.

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treatment. This estimate is consistent with national studies showing that over 6% of male inmates have a severe mental disorder and the rate of severe mental illness among women prisoners is about 15% (Teplin et al., 1996). The number of inmates wanting mental health care is about 16%, according to recent data from the U.S. Department of Justice (1999). Due to CT's current prison overcrowding, it is anticipated that community-based substance abuse and mental health treatment capacity for offender populations will continue become increasingly limited.

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TABLE 2. Geographic Location	**Total # of Males with MH/SA 3-4**	**Total # of Females with MH/SA 3-4**	**Total # Individuals**	**Approx. 30-35% will be Screened Eligible for *CORP***	**Total To Be Served By *CORP***
Hartford	110	22	132	30-35%	Approx. 40 annually
New Haven	116	26	142	30-35%	Approx. 40 annually
Bridgeport	65	17	82	30-35%	Approx. 40 annually
TOTALS	**291**	**65**	**356**	**N/A**	**120 Annually**

The total offender population supervised in the community includes approximately 55,070 on probation, almost 2,010 on parole, and another 1,300 in the community under DOC supervision (i.e., transitional supervision, furlough, and halfway house release). The **Judicial Branch's Court Support Services Division (CSSD)-Probation** provides intake, assessment and supervision services for court-involved individuals. Of the 55,070 individuals currently under CSSD-probation supervision, 78% are males and 22% females and the ethnic composition is 51% White; 28% African Origin; and 19% Latinos. CSSD estimates that nearly 80% of CSSD clients (pre-trial and sentenced) have a diagnosable behavioral health disorder. CSSD has also estimated that a significant number of these clients are homeless or in need of housing assistance. The demographics of the 2,010 individuals under **Board of Parole** supervision includes: 92% males, 8% females, 49% of African Origin, 28% Latinos, and 23% White. **Probation** and **Parole** are both responsible for monitoring the conditions of probation and parole in order to hold offenders accountable and to promote public safety and offender rehabilitation. Both agencies will have staff assigned to the *CORP's* transition team within each local targeted community. Of the 199 inmates referred to DMHAS' Forensic Unit in State Fiscal Year 2001, 93% were males; 7% were females; 56% were of African Origin; 26% White; and 19% Latino. Over 75% of these individuals had a significant mental illness and co-occurring substance use disorder. Approximately 99% of these individuals' committed serious and/or violent offenders, including sexual assault, assault robbery, possession and sale of illicit substances, and manslaughter. Additionally, over 38% of these individuals were homeless at the time of referral.

State Data. As part of its ongoing assessment of treatment need, funded by the federal Center for Substance Abuse Treatment (CSAT), DMHAS commissioned Yale University to interview adult arrestees (Schottenfeld, 1996). The Substance Abuse Need for Treatment among Arrestees study was conducted in two of the state's detention centers located in Hartford and Bridgeport. The interview consisted of questions from both the Drug Use Forecasting and the Structured Clinical Interview for DSM-IV. Approximately six in ten arrestees interviewed (57% of men and 61% of women) were dependent on one or more substances. Of the arrestees interviewed 33% reported cocaine dependence, 18% reported heroin dependence, 10% reported marijuana dependence, and 31% reported alcohol dependence. The vast majority (91%) of heroin dependent males reported a current need for treatment, but very few (10%) were currently in treatment. A significant proportion of heroin dependent male arrestees (32%) had never received any substance abuse treatment, including detoxification. The majority (52%) of substance dependent females reported a current need for treatment, but very few (19%) were currently in treatment. Reported need for treatment was also extremely high among women dependent on cocaine (86%) or heroin (82%).

Geographic Areas. The selected geographic areas for the *CORP* are the cities of Hartford, New Haven, and Bridgeport. These geographic areas were targeted due to a clear need demonstrated by supportive data from the DOC which shows a majority of individuals with co-occurring disorders will be released into these communities. Additionally, these urban centers are stressed by significant social and economic problems, having some of the highest national rates for crime, violence, school dropout, and drug arrest. They have also been severely affected by the region's economic decline, having the highest unemployment rates and the lowest per capita income level in the state.

Geographic Area	Population, Race/Ethnicity, and Unemployment Rate *Overall the Unemployment Rate is 3.4% in Connecticut
Hartford	The state's 3rd largest city with a population of 121,578, is comprised of 27% White, 38% African Origin, and 41% Latino. The Unemployment Rate in Hartford is 6.5%.
New Haven	The state's 2nd largest city with a population of 123,626, is comprised of 37% African Origin, 42% White, and 18% Latino. The Unemployment Rate in New Haven is 4.5%.
Bridgeport	Bridgeport, the largest city in CT, has a population of 139,529,comprised of 40% White, 30% African Origin, and 31% Latino. The Unemployment Rate in Bridgeport is 5.9%.

Voluntary vs. Involuntary. *CORP* will serve all individuals who are eligible for services, regardless of whether they are under supervised release. For those individuals under formal supervision, such as parole or probation, participation in the program shall be a condition of release. Consequences for program noncompliance for these individuals will be addressed through the process of graduated sanctions. For those individuals released under no formal supervision, case managers will utilize culturally appropriate engagement, retention, and motivational enhancement approaches to develop and maintain trust with the individual and facilitate his/her community reintegration planning.

Cultural Competence. With Connecticut's 2000 census reflecting a 31% increase for Latinos; a 10% increase for African Origin populations; and a 63% increase for Asian and Pacific Islanders, there is an urgent need for more effective, evidence-based, and culturally appropriate strategies for treating both substance use and mental health disorders among CT's diverse communities. Racial disparities exist in CT's prison population, as seen around the country. Although Latinos constitute 9% of the state's population, they constitute 27% of the adult criminal justice population. Similarly, individuals of African Origin constitute 9% of the state's population, but constitute 47% of the adult criminal justice population. Greater understanding of and respect for diverse cultures leads to better treatment efforts. Evidence also exists that an ethnic/racial match of therapists, as well as agency location in the ethnic/racial community contributes to treatment retention (Flaskerud, 1986). These strategies must include ways of engaging those in need of treatment to seek treatment, to stay in treatment, and to continue their recovery within their communities.

Culturally appropriate services for Latinos must take into account cultural characteristics including *familiarismo, simpatico,* and *personalismo* (Gomez et al., 1994). *Familiarismo,* or the importance of the family as a social unit and source of support, can be a barrier to service providers, with whom Latino persons may not share their concerns. On the positive side, it can be a powerful factor to motivate behavior change. *Simpatico* refers to the importance of polite social relations that shun assertiveness, negative responses and criticism. Providers need to be aware that Latinos may appear to agree with a message that they may not understand or intend to follow (Alegria et al., 1998). *Personalismo* refers to the preference for relationships that reflect familiarity and warmth. Specifically, cultural programs for Latinos should emphasize family membership and affiliation, "*simpatico"* (positive interpersonal relationships), and "*respecto*" (the need to be treated with deference respect) (Alegria et al., 1998: Nyamathi et al., 1994). A culturally competent practitioner should be aware of belief systems that might play important roles in the ways substance use and mental health disorders are both perceived and treated, such as "*santeria*" and "*espiritismo*". Additionally, an understanding of the greater involvement of the Latino community, including churches, spiritual healers, "*herbalistas*", and community leaders in the recovery process.

Cultural programs for African Origin populations should emphasize spirituality, respect for tradition, harmony with nature, the importance of the community, rites of passage, the concept of the council of elders (Jackson et al., 1997) and Afrocentric history. The use of Afrocentric approaches, which reflect committed attitude or way, may be used to further enhance the development of a broader spectrum of perspective styles of thinking, and insight in treatment (CSAT, 1996). Additionally, the church can play an instrumental role in the treatment and recovery of African Origin populations. For centuries the church has played a caring and healing role in their communities, and, to a great extent, it has become a surrogate extended family.

Sensitivity to Gender and Sexual Orientation. Current literature recognizes the importance of offering gender-specific programming that is based on the realities of women's lives and on the identification of women's strengths. Gender-specific

programming offers a safe and supportive environment, promotes bonding among women, and has a strong female presence in staff trained to be sensitive to women's issues (Finkelstein, et al., 1997). Because women have multiple roles, they also encounter multiple systems of care: the mental health, substance abuse, and criminal justice systems, the child welfare and school systems, and social services systems, especially for employment, housing assistance, and income supports. The complexity of these systems for persons with limited education, and who are especially stigmatized if they have abused alcohol or drugs, means that these mothers need case management to help with advocacy, coordination, and reduce systems fragmentation (Brindis &Theidon, 1997). Another area requiring specialized attention is that of gay and lesbian issues. Treatment models for gay and lesbian individuals emphasize knowledge of the development and management of a lesbian or gay identity, an understanding of the origins and influence of heterosexist belief systems, and awareness of issues specific to lesbian and gay individuals. (Browning et al., 1991). Gay-affirmation treatment approaches specific for ethnic minority lesbian and gay consumers highlight an awareness of the effects of having a bicultural status such as the marginalization of lesbian and gay clients in both the gay and ethnic minority communities, and the experience of conflicting loyalties for both communities (Greene, 1994; Morales, 1990).

Trauma. There is extensive literature documenting a high co-morbidity between exposure to psychological trauma, post-traumatic stress disorder (PTSD), and mental health and substance use disorders (Breslau et al., 1991; Cottler et al., 1992; Deering et al., 1996; Kessler et al., 1995; Stewart, 1996). Sexual abuse history is strongly associated with increased rates of substance abuse (Briere and Zaidi, 1989; Swett et al., 1991), and populations of persons with behavioral health disorders report high rates of physical and sexual trauma (Dansky et al., 1995; Deykin and Buka, 1997; Kovach, 1986; Miller et al., 1995, 1993; Trifflemanet al., 1995; Wassermanet al., 1997; Wilsnack et al., 1997). Clearly, trauma exposure, the development of PTSD, and mental health and substance use disorders are likely to be intertwined, to produce substantial psychosocial impairment (Brown & Anderson, 1991; Goff et al., 1991; Rose et al., 1991; Stewart et al., 1998), and to interfere with treatment recruitment and retention (Brown et al., 1998) and treatment outcome (Palacios, 1999) unless addressed through integrated treatment.

HIV/AIDS, STD, and Hepatitis Data. In 2000, CT ranked 15th nationally in the number of AIDS cases and 6th in AIDS cases per 100,000 population. Drug use is the source of over 52% of the AIDS cases in the state. HIV increasingly and disproportionately affects Latino and African Origin populations, including offenders. (CT HIV Surveillance, 1999). The reported primary source of transmission of HIV for Latino and African Origin males (67%) is injection drug use and for African Origin and Latina females (48%) heterosexual contact. Other alarming statistic in CT relates to Sexually Transmitted Disease (STD), TB, and Hepatitis C Virus (HCV) rates, all of which the prevalence is highest (67%) among injection drug users. The burden of HCV is also a significant health issue for offender populations. Data from CT indicates that counseling and testing for HIV, STDs, TB, and HCV should be provided in all substance abuse treatment.

Supervision, Substance Abuse, Mental Health, and Employment Needs. The target population identified in this proposal as serious and violent young mentally ill adults in the correctional system with co-morbid substance use disorders is particularly vulnerable to arrest and recidivism. The multiple problems that this population faces cannot be adequately addressed by traditional community-based services. Factors identified as related to poor treatment outcomes include a history of resistance to treatment, non-compliance with psychoactive medications, and refusal of appropriate housing placements. Researchers have indicated the need for service models that improve the liaisons between the criminal justice system and the treatment systems. In addition, an enhanced integration between the mental health and substance abuse treatment services has been advocated as the most efficacious approach to the provision of services (Rock, 2001).

Research has demonstrated that the prevalence of severe mental disorders within correctional populations is significantly higher than in the general population (Teplin, 1990; Chiles, Von Cleve, Jemelka, and Trupin, 1990). Data on the co-occurrence of a substance use disorder among the correctional population with severe mental disorders demonstrates a significantly high rate as compared to the general population. The rate of co-disorders among correctional populations has been reported to be as high as 72% of inmates with a current serious illness, with lifetime co-disorder rates as high as 94% (Abram and Teplin, 1991). In one study, all offenders with a diagnosis of schizophrenia, schizophreniform disorder, or mania were given a diagnosis of drug or alcohol abuse or dependence (Chiles, Jemelka, and Trupin, 1990).

In one study, 43% of the defendants with mental health disorders were homeless at the time of the crime for which they were arrested. The rate of homelessness was 21 times higher in the overall sample of defendants than in the overall population of mentally ill persons in the city in which the study was conducted (Lamb, et al, 1998). In another study, 30% of the participants reported that they would be homeless on release (Hartwell and Orr, 1999). Interestingly, recidivism has been found to be significantly associated with residential instability (Lamberti, et al., 2001). Another important factor in recidivism is the high rate of unemployment demonstrated to be associated with this population. Studies have shown that between 80 and 90% of persons within this population are unemployed (Lamb and Weinberger, 1998). Further, persons of color are over-represented within this population; therefore the relevance of cultural issues in preventing incarceration of this population should be given serious attention. (Lamberti, et al., 2001). Thus, offenders with co-occurring disorders need vocational assistance in addition to case management, and all staff must be carefully trained in cultural competence.

CORP and Risk Reduction. The provision of intensive community case management to address the treatment and service needs of this population has been demonstrated to be effective in reducing recidivism and re-arrest. One contributing factor to the success of intensive case management approaches to working with this population has been the initiation of, and consistency in, case management services within the correctional system itself prior to release (Ventura, et al., 1998; Godley, et al., 2000). Persons with co-

occurring mental disorders need case management in order to address their high levels of need for complex services. Although treatment is an important need, housing and the supportive services offered by case managers may be even more important.

The Hare Psychopathy checklist-Revised (PCL-R) is widely used in the DMHAS system and will be incorporated in the risk assessment for this offender population. All offenders entering the community with probation stipulations will be screened by probation officers using the LSI-R (Level of Service Inventory-Revised) risk assessment system. As discussed in previous sections, the target population for this initiative is at heightened risk for arrest and recidivism due to mental illness often complicated by substance abuse. Therefore, risk factors will focus especially on substance use, housing instability, treatment resistance, command and paranoid hallucination history, impulsive behaviors, violence and threat of violence towards self and others and criminal history.

The Risk Review Team will review the offender assessment (including any and all risk assessments) and provide feedback for the development of a risk management which will optimize client, staff and public safety, and well as enhance the ability of the community provider to develop effective risk management strategies. The risk management plan will be incorporated into the Offender Reentry Plan.

CONNECTICUT OFFENDER REENTRY WORKPLAN

4. Organizational Capacity/Decision Makers

Lead Agency Capacity. DMHAS is organized to promote comprehensive, client-based services in the areas of behavioral health services to ensure the programmatic integrity and clinical identity of all services. This initiative focuses on the most vulnerable and needy population: men and women released from the state's correctional facilities with co-occurring disorders. DMHAS has continuously recognized the unique recovery needs of various populations in the state. DMHAS has extensive experience working with vulnerable populations with co-occurring disorders. Additionally, DMHAS, through its Office of Multicultural Affairs (OMA), continues to demonstrate its commitment to reach out to individuals from all ethnic/racial backgrounds and provide culturally appropriate services. DMHAS is dedicated in continuing to establish multicultural practices throughout its system as it works toward the critical goal of developing a fully culturally appropriate service system. This system recognizes that consumers, families, providers, and community participation are critical components to reaching this goal. DMHAS has established a strong foundation in cultural competency and will further implement this process through the Connecticut Offender Reentry Program (*CORP).*

State Partnership Readiness. The following factors contribute to CT's readiness to implement a comprehensive, integrated approach for individuals released from CT's correctional facilities with co-occurring disorders:

- **Leadership**. DMHAS is a leader among state agency heads, community-based providers, and consumers who recognize the value of successfully addressing substance abuse issues, mental health needs, community safety, employment, and housing issues for serious and violent offenders returning to our communities. To

facilitate strong support and coordination of this effort, the Governor's Office initiated a Memorandum of Agreement (Attachment 3-MOA). This agreement sets forth the level of commitment of state agencies that are involved with the target populations and their roles. Vision and Strategic Planning is in place to develop, mobilize and sustain an integrated and innovative treatment agenda for individuals released from CT's correctional facilities with co-occurring disorders. The *CORP* planning and implementation plan will build on the recommendations of CT's Alcohol and Drug Policy Council and Mental Health Policy Council to develop a treatment system that addresses the cultural needs of the target population.

- **Commitment and Partnerships with Key Stakeholders**. DMHAS, through its Forensic Unit, provides an array of community forensic services for individuals released from prison with psychiatric and/or substance use disorders. These services include forensic mental health and addictions evaluations, consultation, oversight, and a seamless service system to reduce the occurrence of critical incidents. DMHAS' Forensic services seek to enhance public and employee safety, service delivery, quality care, and professional development. The **Department of Correction** (DOC) operates 20 prisons and jails throughout the state, housing nearly 18,000 inmates. From 1985 to 2000, the average daily prison population rose from 5,813 to 17,466, an increase of 200 percent. Throughout most of the past 15 years, the prison system has routinely operated at or over capacity. The Judicial Branch, Court Support Services Division- **Probation Unit** (Probation), is responsible for monitoring the conditions of probation and pretrial supervision set by Connecticut judges in order to hold offenders accountable and promote public safety and offender rehabilitation. The **Connecticut Board of Parole** (Parole) is responsible for the parole decision-making process and the terms and conditions of parole. Parole is committed to protecting the public by making responsible decisions regarding when and under what circumstances eligible offenders will be released from confinement. The Connecticut Employment and Training Commission-State **Workforce Investment Board** (WIB) is CT's highest workforce development policy body. The WIB has the responsibility to develop policy for a statewide workforce system to reduce fragmentation and duplication of workforce services and achieve full workforce program integration.

- **New Collaboratives**. To address the issues of serious and violent inmates with significant mental health disorders automatically being denied parole, DMHAS and Parole have recently finalized policy and procedures by which inmates with significant mental health disorders and who are eligible for parole are not automatically denied Parole due to their mental illness. DMHAS, through *CORP*, will continue to work with Parole in pre-release planning for these individuals to develop a community reintegration plan that includes mental health and substance abuse treatment and employment and housing planning.

The *CORP* will be the vehicle utilized by DMHAS and its partners to cooperatively develop, validate, refine, and deliver a newly integrated substance abuse, mental health, community supervision and safety, employment, and housing strategy for the target

population. DMHAS will facilitate the "bridging" process among key state agencies, community-based providers, and families within *CORP*. Community-based providers, families, researchers, and key state agencies will be encouraged to be involved in all phases of *CORP* development, from the conceptualization to the implementation and the on-going operations. Through their active involvement with *CORP* and its cross-training activities, key state agencies, community-based providers, and families will be sensitized to each others viewpoints and begin to build a sense of ownership, trust, and investment in *CORP*.

Reentry Steering Committee (RSC). In keeping with DMHAS' commitment for maximizing consumers and stakeholders' choice and empowerment, DMHAS has implemented a Reentry Steering Committee (RSC). The RSC, with representatives from DMHAS, DOC, Probation, Parole, WIB, the treatment provider, the community programs, representatives from the educational arena, representatives from faith-based organizations and community agencies serving Latino and African Origin communities, and individuals who have walked this path into recovery, family members, and other key stakeholders as defined in the Program Announcement (PA), will ensure that *CORP* is well managed and rooted in CT's multifaceted system. The RSC will be co-chaired by representatives from DMHAS, DOC, Probation, Parole, and the WIB and no less than 51% participation of community organizations, ex-offenders, and individuals in recovery. Through this process, stakeholders will fully participate in directing program development and oversight including planning for recruitment and delivery of culturally appropriate services. The RSC will serve as an expert panel in the review of issues or concerns related to project components, delivery of services, protocols, and recruitment and retention strategies.

Partner Responsibilities. As the lead agency for the initiative, DMHAS will be primarily responsible for the direct provision of treatment services and the overall coordination of the identified services both within and outside of the correctional setting. **The Department of Correction** will be instrumental in assisting in the identification of appropriate target population individuals, the identification of treatment needs, skill deficits, and risk factors, the development of the community integration plan, and the provision and collaboration of services to the identified individual within the correctional setting. Individuals not meeting eligibility criteria will continue to be referred to appropriate DMHAS services by the Department of Correction through the existing DMHAS/DOC referral system. The **Board of Parole** and the **Department of Adult Probation** will have the primary responsibility for community supervision and monitoring the conditions of probation and parole in order to hold offenders accountable and to promote public safety and offender rehabilitation including the imposition of graduated sanctions. Both entities will be involved in the development of the community reintegration plan and the coordination of community services once the individual has been released into the community. Parole, Probation and DMHAS will share the focus of community and treatment commitment compliance. Like all the partners, representatives from the **Workforce Investment Board** will aid in the development of the reintegration

plan by providing information and technical aspects in the area of employment and vocational services.

Project Sustainability. The applicant Executive Branch agency (DMHAS) and its partners from the Executive Branch (DOC and WIB) and Judicial Branch (Probation and Parole), plan to utilize an appropriate planning process that integrates sustaining this project through its statewide interagency coordination and resource development efforts. This initiative is consistent with the state's direction of funding gaps in services utilizing evidence-based model programs. Every effort will be made through interagency collaboration and resource leveraging to garner funds needed to continue and to replicate this critical initiative. Additional collaborative resource development efforts will be spearheaded by the RSC.

It is anticipated that this proposed intervention strategy will demonstrate to policy makers the importance of continued funding. This includes: 1) promoting effective linkages between levels of care to best meet the needs of individuals with co-occurring disorders released from CT's correctional facilities; 2) increasing the likelihood of successful treatment outcomes (e.g. decreased recidivism and/or no alcohol or other drug use, employment, housing, risk reduction, improved health and social functioning); 3) increasing access and appropriateness of needed integrated substance abuse and mental health treatment, employment and housing services for the target population; 4) providing for significant cost savings resulting in expanded treatment capacity both through greater utilization of services and redistribution of savings to clearly identified treatment needs; and 5) generating cost-offsets in other systems, such as health care, criminal justice, and social services. DMHAS and its state partners, as administrators of the federal Substance Abuse Block Grant, Community Mental Health Block Grant, Workforce Investment Funds, including One-Stop Centers funding, DOJ Formula Grant Programs, and other related Formula Grant Programs, are in the premier position to assure continuation of the *CORP*.

DMHAS, through several federal demonstration projects, has established mechanisms for implementing evidence-based models by systematically identifying federal, state, and private resources; coordinating efforts for redirecting resources to maximize efficiency and improve quality; and initiating innovative resource development strategies. Success in leveraging and matching federal and foundation funding has placed DMHAS in the forefront of testing and replicating new evidence-based behavioral health treatment strategies and sharpening interagency and local collaboration. All these tools will be used to ensure the sustainability and replication of the *CORP* model.

Initiative Evaluation - How Data will be Organized, Collected, and Shared for the Local and National Evaluation. DMHAS collects data on all persons receiving services in state operated and state-funded mental health and substance abuse service agencies—virtually every public and private non-profit agency serving people with behavioral health disorders. These data are maintained in a central repository. DMHAS also has the capacity to design routine data collection to meet the evaluation needs of new programs.

For the *CORP*, through standard reporting mechanisms we will collect data on demographic and clinical characteristics, and dates and amount of time for each service rendered, by agency. We will supplement this information by having program staff record the following data: Specific service activities performed during each encounter with service staff, (e.g., housing assistance, job placement, money management, etc.); Employment status and earnings, as reported by the client, with confirmation from employers in most cases; Education entry and retention; Rearrest/recidivism, as shown in the CT Justice Information System; Incarceration days, available from DOC; Client demographics; Monthly ratings of stage of treatment, per the New Hampshire stage-wise integrated treatment model; and Monthly ratings of substance use. These data will be used to track the progress of clients in the program, and also to assess project fidelity.

The Research Division at DMHAS, directed by Linda Frisman, Ph.D., will create a supplemental data system, and will develop regular data reports for the program managers and staff. The Evaluation Coordinator will create an overall evaluation report annually to describe the number of persons served, their characteristics, the types of services received, the rates of employment, arrests, and the number of days incarcerated. Because of other studies being conducted by Dr. Frisman, including the SAMHSA Jail Diversion program, we will have available a comprehensive list of unit costs with which to calculate actual program costs, system costs, and extra-system costs. Dr. Frisman recently completed data collection for the Jail Diversion study and the CMHS Housing Initiative, and currently is the PI of two additional SAMHSA-funded outcome studies, in addition to several evaluations of SAMHSA service grants. DMHAS is poised to propose a rigorous outcome study, or to cooperate with other evaluators in a national outcome study, should federal funds for such an outcome study become available.

Evaluation Study Team. Linda Frisman, Ph.D., the **Project Evaluator**, will have ultimate responsibility for the design and conduct of the evaluation, and will supervise the Evaluation Coordinator (TBH) and the Data Manager. Dr. Frisman is the Principal Investigator for four federal Substance Abuse and Mental Health Services Administration (SAMHSA) funded projects: the CMHS Housing Initiative, the Jail Diversion study, the Homeless Families study and Co-occurring Substance Abuse and Trauma Disorder study. The DMHAS Research Division staff are employees of the Psychology Department at the University of CT. The Research Division is committed to hiring persons who are in recovery, and persons of diverse cultural backgrounds.

5. Design Each Phase of Initiative

Transition Team Membership. Offenders participating in the Connecticut Offender Reentry Program (*CORP*), will be followed through all phases by members of the transition team whose level of involvement will fluctuate dependent on the phase and needs of the offender. At a minimum, the transition team will comprise the *CORP* case manager, the *CORP* vocational counselor, correctional treatment and supervisory staff, probation and parole representatives, community treatment providers, members of the risk review team, and DMHAS clinical management staff. The *CORP* case manager will function as the case lead for each of the participants and will ensure communication and collaboration around the changing needs of the reentry and treatment plans.

Phase I – Institutionally Based Programming

Phase I includes the planning and institutional phases of the *CORP*. DMHAS and its partners will collaborate to develop a comprehensive treatment and service system that is responsive to the needs of Connecticut's culturally diverse offender population. The development and implementation of *CORP* will provide for a sequential process, both for planning and implementing each phase in the targeted areas. The planning phase will be organized as follows:

Start-Up. During the start-up phase, the following key steps will occur: recruit, hire, and train project staff, develop subcontracts with community providers, enhance the current membership of the Reentry Steering Committee (RSC) to assure that key stakeholders, including DMHAS, DOC, WIB, Parole, Probation, incarceration centers, prosecutor/district attorney's office, and local workforce investment boards, law enforcement agencies, elected officials, parole, substance abuse, mental health, housing, education, public health providers, victim advocacy organizations, community- and faith-based organizations, the recovery community, ex-offenders, and minorities are represented, initiate the organization of local workgroups with representation from local workforce investment boards. Special efforts will also be made to include private/public foundations, including the Hartford Foundation and the Greater New Haven and Bridgeport Foundations.

Develop Reentry Steering Committee (RSC). The RSC will provide a forum and create an environment in which key stakeholders can move forward to shape creative solutions to address mental health, substance abuse, employment, housing, and community safety issues for the target population. This grant has been accepted by the Governor's Office (Attachment 2-MOA) and supported by several state agencies

(DMHAS, DOC, Probation, Parole, and WIB) who have pledged their commitment to the goals of the grant by signing the MOA. During this phase, a detailed work-plan, including the coordination and implementation of the project, and all procedures, forms, and instruments for program operation, will be created.

Cross Training of Key Stakeholders and Project Staff. Key stakeholders and project staff will receive cross training on CT's mental health, substance abuse, criminal justice, entitlements, child welfare, employment, and education systems and other issues that affect the success of the project and are deemed essential to the development and coordination of the services.

Existing Institutional Programming. Currently, the Department of Correction offers a varied and extensive menu of programs for incarcerated individuals. Categories of programs are listed below with a small listing of the types of services offered:

- Health Services (substance abuse and mental health education, treatment, AIDS awareness, AA, Alanon, Therapeutic Writing, Relaxation Training)
- Religious Services (Religious study and Worship services for a wide range of denominations)
- Recreation Services (Gym, Therapeutic Recreation Class),
- Self Improvement (Anger and Stress management, Art Programs, Income Tax Preparation, Values Clarification)
- Sex Offender Programs
- Victim Services (Victim-Offender Dialogue, Victim Educational Services)
- Volunteer/Community Services (Bicycle and wheelchair repair,
- Institutional Employment (Graphic Arts, Janitorial, Industry Warehouse, Textile Shop)
- Educational (Basic Adult Education, Business Education, GED)
- Vocational (Institutional employment cabinet making, carpentry, certified Nurse's Aid Programs, Horticulture, Hospitality, Chef)
- Transition to Community (Job Skills, School to Work)

Access to programs is dependent on factors related to availability and risk classification issues. DOC will make every effort to ensure access for the offender target population where and when appropriate.

Pre-Release Assessment/Individualized Reentry Plan. During the year prior to the offender's to release, a comprehensive and individualized community reentry plan, based on the pre-release assessment, will be coordinated by DOC and DMHAS with input from criminal justice supervision entities. Outreach, engagement, and assessment of the target population will be accomplished through a three-tier process. First, clients will be identified through the existing DMHAS and DOC referral infrastructure. Because this system, which has been in place since 1996, has been successful, we will continue to use

the existing structure to enhance our referral and service network. DOC will refer clients to the project. DMHAS' Forensic Unit will then conduct an initial intake and screening of the client to determine eligibility. DMHAS will make the formal referral to the appropriate *CORP* treatment team to which the individual is anticipated to return. The *CORP* case managers will then meet (face-to-face) with the individual to conduct a gender-specific and culturally sensitive screening. This screening will provide the offender with an overview of the program to determine if the client is interested in pursuing the possibility of participating and further determine whether the individual is appropriate for *CORP*. Individuals' not meeting eligibility requirements but needing other types of services will be referred to other community providers. Second, a clinical assessment will build upon the initial intake for those clients in need of treatment intervention. An in-depth assessment of the individuals' substance use, mental health status, housing situation, employment, medical, and family circumstances will be conducted to determine the appropriate level of care required. This assessment will include but not be limited to:

- Current and historical life information including age, gender, sexual orientation, cultural background, spiritual beliefs, employment and educational history, legal involvement, family history and relationships, including natural supports, and history of trauma, including sexual abuse
- Physical health history and current status, including HIV risk and/or status
- Medication use profile, including allergies and other adverse reactions
- Substance use history, including tobacco, alcohol and other drugs
- Previous behavioral health services including diagnostic information, treatment information, efficacy of current or previously used medication, and prior psychiatric evaluations and/or testing
- Mental status
- Cognitive, emotional and behavioral functioning
- Abilities, aptitudes, skills and strengths
- Interests
- Individualized goals
- Criminal history and risk assessment for behaviors that pose a serious threat or danger to the client or others.
- Medical history

This assessment will be repeated six months prior to release, and then three months prior to release to ensure accurate mental status once discharge occurs. Upon completion of the in-depth assessment, a comprehensive community reintegration plan, with recommendations for integrated substance abuse and mental health treatment, and employment and housing support services, will be developed with the client and the treatment team. Members of the team include the case managers, clinicians, vocational specialists, DOC, Parole, Probation, and DMHAS' project manager.

Risk Assessment. A risk assessment will be conducted by the treatment team member as part of the initial in-depth assessment and then reviewed with the Risk Review Team.

The Risk Review Team will include senior clinicians with expertise in forensic services. As part of the risk assessment process, the risk review team may request a consultation from the DMHAS consulting Forensic Psychiatrists. Risk assessments will identify risk factors for reoffending, violence and high-risk behaviors. This risk assessment will then inform a risk management plan which will incorporate strategies for reducing risky behaviors and will mandate the development of a crisis and risk management plan. The Hare Psychopathy checklist-Revised (PCL-R) is widely used in the DMHAS system and will be incorporated in the risk assessment for this offender population. All offenders entering the community with probation stipulations will be screened by probation officers using the LSI-R (Level of Service Inventory-Revised) risk assessment system.

Voluntary vs. Involuntary. *CORP* will serve all individuals who are eligible for services, regardless of whether they are under supervised release. For those individuals under formal supervision, such as parole or probation, participation in the program shall be a condition of release. For those individuals released under no formal supervision, case managers will utilize culturally appropriate engagement, retention, and motivational enhancement approaches to develop and maintain trust with the individual and facilitate his/her community reintegration planning.

The case managers, through Motivational Enhancement Therapy (MET) and focus on basic needs, will engage (pre-and post-release) persons in the target population and help to develop a community reintegration plan which will connect them to integrated mental health and substance abuse treatment, employment, and housing services and facilitate their transition from prison to the community. They will ensure that coordinated linkages to mental health and substance abuse treatment, employment, housing and other supportive services are in place to help the individual maintain his/her recovery and assure successful reintegration into the community. A continuum of case management, supervision and services will be effectively coordinated among DMHAS, DOC, Parole, Probation, and WIB and its local partners.

***CORP* Institutional Programming/Treatment Services.** This phase of the program will expand and enhance current efforts between DMHAS, DOC, Parole, Probation, and WIB to ensure continuity of care for men and women released from CT's correctional facilities with significant mental health and co-occurring substance use disorders. The full continuum of services will include the pre-release planning assessment to identify individuals' mental health, substance abuse, employment, and housing needs and assistance with obtaining and securing these services upon release. The primary goal is to successfully reintegrate the client back into the community. Offenders targeted for the *CORP* program will be receiving treatment services in addition to services already available within the institutional setting. Programming will focus on strengthening community readiness in those areas identified by the screening and assessment process. Programming available will include services already offered from the institution as described above as well as group and individual services with a focus on skill attainment in the areas of job readiness, symptom management, substance abuse, daily living skills and any other area identified critical to community stability. Appropriate entitlement

applications will be completed the transition team members. They will also serve to foster and encourage the offender's involvement in completing GED and other institutional education programs. Team members may also co-facilitate therapeutic treatment groups with the institutional clinical staff dependent on the needs of the client. . Family involvement will be promoted through the use of "professional visits" facilitated by a treatment team member.

Phase II Community-Based Transition

Description of Service Providers DMHAS' Local Mental Health Authorities (LMHA), Capitol Region Mental Health Center (CRMHC) in Hartford, Community Mental Health Center (CMHC) in New Haven, and Greater Bridgeport Community Mental Health Center (GBCMHC) in Bridgeport, will expand and enhance their capacity to facilitate the provision of safe and effective community treatment of high-risk individuals through community treatment teams. These provider agencies are all state operated units of the DMHAS Healthcare System. Each LMHA provides triage/intake services, case management services, psychosocial rehabilitation services, outpatient services, respite services, homeless outreach, peer support, and a client driven and operated Drop-In Center, in addition to the Assertive Community Treatment (ACT) teams for individuals with co-occurring disorders and a variety of other networks that serve the criminal justice populations with co-occurring disorders. They will keep program participants within their community and involve the entire community in the reintegration of renewed and participating individuals.

The *CORP* case manager and vocational manger, employed by the LMHA, will utilize the New Hampshire (NH) model of integrated stage-wise treatment for co-occurring disorders and the Individual Placement and Support (IPS) model for vocational supports. A team approach with the criminal justice supervisory entities will help to inform decisions about changes in custody, placement, and supervision. The newly enhanced treatment teams will have expertise in reintegrating the target population back into the community. Connecticut's strategy comprises these various components:

Intensive Case Management. Issues pertaining to ongoing recovery and treatment retention of the target population require intensive case management. Appropriate management of the individual in pre-release and in the community engages and encourages him/her towards successful completion of individually crafted treatment and personal goals leading to a reduction in risky behavior and assuming a positive role in the community. Coordination of services demands an integrated approach to managing the needs of this population, therefore the *CORP* case and vocational managers, through recommendations from the transition team, will be instrumental in following the clients' progress throughout the team of treatment providers. As the case lead for the offender, the case managers' responsibilities will include employment service and housing coordination, advocacy, and assistance in dealing with health, social services and treatment agencies during both the pre- and post- institutional release stages. Other responsibilities include working closely with probation and parole officers, the courts, and local law enforcement agencies on issues related to community supervision and safety.

Case managers will employ strategies to help engage the person pre- and post- release, and to address any barriers to attending treatment. In similar projects, we have found that

the case manager's initial focus on basic needs creates a useful alliance with the client that facilitates treatment engagement. Simultaneously, the identification of difficulties associated with attending treatment can be addressed. Case managers will use non-confrontational strategies to motivate the client to attend treatment, as described in greater detail below. An important function of the case manager is to serve as a recovery coach, who applauds successes, but is non-judgmental about lapses. The case manager accepts the goals of their clients, and helps clients recognize when their behavior is in conflict with those goals. The overall steps of the case management process will be the following: 1) **Identification and Prioritization of Practical Concerns.** Using a worksheet specifying possible areas of life concerns, e.g. housing, employment, finances, health, the client and case manager will list concerns relevant to that client in each area, assigning each a priority score of 1 to 10; 2) **Goal-setting.** A simply stated goal will be written for each top priority concern; 3) **Specification of the Steps Necessary for Goal Achievement.** All of the steps do not need to be identified; steps may be identified sequentially, over the course of the case management; and 4) **Implementation.** The case manager helps the client to follow through with the specified steps (e.g., making the phone calls, filling out applications, attending appointments, etc.), sometimes doing these with the client, at other times providing the client with the information and encouragement necessary to complete the steps on his/her own.

Case managers will assist each individual in making immediate application for any entitlements for which he/she may be eligible. DMHAS, in collaboration with the CT Department of Social Services (DSS), is currently piloting a program in which inmates are assisted in applying for entitlements prior to their release from prison. DMHAS will work closely with DSS to pilot a similar project for participants of the *CORP*.

Integrated Mental Health and Substance Abuse Treatment. Integrated, (outpatient, intensive outpatient, day treatment, and residential) mental health and substance abuse treatment services, involving culturally appropriate, gender-specific and person-centered approaches, will be available for all *CORP* participants. The service providers will use an evidence-based model of engagement and clinical treatment. The New Hampshire model incorporates elements of Motivational Enhancement Therapy (MET), but also includes specific types of groups reflecting the individual's stage of development. Also, counselors identify the function served by the client's substance use, and conduct sessions in skill building. The development of certain types of skills helps the client prevent relapse related to specific deficits. For example, if the client uses drugs to facilitate social contact, the counselor teaches more appropriate ways to make friends, so that isolation from fellow users will not cause relapse. Treatment at the four-targeted sites will extend over a six to 12-month period using a comprehensive treatment team model. Intensity of services will be flexible and tailored through individualized treatment service plans and routinely reviewed by appropriate members of the transition team. Particular attention will be paid to co-morbid conditions, e.g., medical problems, trauma history, depression, with a treatment program designed to address these issues. Treatment will be provided by clinicians familiar with the person's living conditions through mobile home-based outreach and collaboration with transition team members. The continuing emphasis in care will be to address individual and social crises or needs (employment, housing,

entitlements, food, family) which might trigger abuse of substances or criminal activity as the person is treated for his/her co-occurring disorders.

Medical Services. Medical examinations and follow-up care will be a standard component of community services. As part of the discharge planning, all applications for benefits and entitlements will be completed prior to the discharge date. State medical benefits will allow most individuals to medical coverage for such services. When entitlements are not approved for such medical care, some medical care can be provided by the Local Mental Health Authorities. Services needed beyond the scope of the treatment agencies will be sought through other community health care agencies.

Job Skills Development and Job Placement Services. *CORP* will focus on the practice of supported employment. Supported employment is one of the most widely used evidence-based practices for people with serious mental illness. Although there are variations of supported employment models, the Individual Placement and Support (IPS) model is the "most comprehensively described supported employment approach" (Bond, 2001). IPS models incorporate the following principles: 1) competitive employment is the goal, rather than sheltered or transitional employment; 2) job search occurs rapidly after an individual expresses an interest, versus after months of training or waiting on lists; 3) mental health services and employment/rehabilitation services are integrated; 4) jobs are identified or developed that are consistent with consumer interests and preferences; 5) outcomes and process variables are continuously and comprehensively assessed; and 6) support lasts for an unlimited amount of time (Becker & Drake, 1993; Drake, 2001). The research, that forms the foundation for supported employment as an evidence-based practice, has demonstrated that supported employment is more effective than traditional vocational services in competitive employment rates and tenure and consumer satisfaction. *CORP* participants will be assisted in making decisions about education and careers, and in realizing those decisions by implementing a realistic vocational plan. *CORP* will identify or directly provide educational and vocational programs that help participants to achieve their goals and economic self-sufficiency.

Additionally, DMHAS and the CT Bureau of Rehabilitation Services (BRS), through an interagency collaboration, have begun to identify vocational practices as well as gaps in the continuum of care for DMHAS' clients. Through this work, BRS has initiated vocational rehabilitation services for individuals with significant mental illness who need assistance to prepare, find or keep a job. LHMAs will continue to work closely with the local BRS in Hartford, New Haven, and Bridgeport to assist *CORP* participants with job placement, job seeking, vocational training services, post-employment services, transportation, and childcare. Local Workforce Investment Boards (WIBs), as a full partner with DMHAS, shall connect participants with existing vocational slots, One-Stop Delivery System, job coaching and support services, etc.

Housing Supports. As a component of the pre-release planning, case managers will assist program participants in obtaining housing. This includes completing paperwork

associated with subsidies for housing; identifying potential housing units and helping select one; helping the individual negotiate with the landlord, if needed; arranging for assistance in moving personal belongings and arranging for utilities; and helping the individual find affordable furnishings and supplies. In order to retain housing, the case manager will help the person to avoid or resolve conflicts with the landlord and neighbors. CORP will respect the individual's wishes about disclosure of his/her status as a client to landlords and neighbors.

Housing assistance to *CORP* participants will be available through a range of DMHAS' programs. The **Planning and Implementing Housing Options for Long Term Success (PILOTS),** a state-funded program for housing homeless persons, provides dollars for supportive services to agencies that can demonstrate the availability of housing resources for individuals and families who are homeless or at risk of becoming homeless, and who have substance use disorders and/or mental illness. In its first year (2000-2001), 241 units of housing (221 permanent, and 20 transitional) became available. This year and next year, the program is slated to be expanded until at least 500 units are available. The **Homeless Outreach Teams (H.O.T.)** work to engage homeless individuals with mentally illness and addictions and help them access needed housing and services. The **PATH Program**, a federal Center for Mental Health Services (CMHS) funded program, serves clients who are homeless or at risk of becoming homeless who have a serious mental illness or co-occurring disorders. In the past year this program served 1,527 individuals statewide. The DMHAS-sponsored Shelter Plus Care program provides over 650 housing units statewide for homeless individuals who have serious mental illness, or substance use disorders, are dually diagnosed, or have AIDS. Additionally, the **Basic Needs Program** was developed and implemented by DMHAS for the administration of behavioral health benefits for people receiving SAGA. The categories of supports available to individuals include housing, food, utilities, transportation, and clothing.

When all existing housing resources have been exhausted, the program sites will use housing supports, as budgeted, to ensure that homelessness and housing stability are addressed. These housing supports will gradually diminish as program participant transition to stable housing and economic self-sufficiency.

Domestic Violence Programming. Programs geared to domestic violence are offered through a variety of criminal justice entities that may be appropriate for some individuals. Where the individual presents a need but may not be eligible for such program, DMHAS will address on an individual basis through the referral to community programs and/or internal programs already addressing anger management and domestic violence issues.

Integration of Community Resources and Supportive Services. A continuum of services, based on the individual needs of the person, will be provided through linkages. These include: assistance with housing, living skills, Hepatitis testing and care, HIV/AIDS care, education, employment, medical and dental care, child care, family support, transportation, advocacy, support groups, evenings/week-end positive

socialization activities, aftercare services, primary medical care, social services, prevention programs, and entitlement programs. All participants of this proposed project will have access to services they need in order to obtain and maintain permanent housing, increase their skills and/or income; and achieve greater self-determination. The services will be flexible, based on the needs of the individual, and available for as long as needed. All service contacts will initiate in a state correctional facility and continue in the community.

Family Members Involvement in the Reentry Process. Family members, through *CORP*, will be encouraged to be a positive support for the program participant and participate in the reintegration process, with the program participants' consent. For offenders wishing to re-unite with their children, their role as parents will be supported through services that enhance the participants' understanding of child development and parenting skills. Also, when feasible, the program will facilitate maintaining and improving relationships with children currently with temporary caregivers.

Victims' Rights. The victims' right to be treated with fairness and respect, including to be reasonably protected, and to access information about arrest, conviction, sentencing, imprisonment, and release, is guaranteed under the CT Constitution. The Board of Paroles' Victim Services Unit is charged with ensuring that victims are notified pending hearings and advised of their rights and options within the parole process. *CORP* will work collaboratively with Parole to ensure that victims' rights are protected and appropriate notification occurs.

Community Service. Activities related to restitution or community service are routinely available through our criminal justice grant partners. Recommendation for participation in such services will be addressed with those criminal justice partners during the development of the Offender Reentry Plan.

Use of Incentives and Sanctions. As discussed previously, the community team will work very closely with the criminal justice supervisory entities to inform changes in placement and supervision. The use of incentives and sanctions is an integral part of community supervision, particularly in fostering accountability in offenders. Sanctions, or responses to non-compliant behaviors, help hold offenders accountable and protect public safety. Appropriate sanctions will include supervision-oriented responses, such as urine testing and the implementation of graduated sanctions. Noncompliance of clinical treatment issues will be addressed through clinical interventions that may include increased services, case conferences, or an adjustment of the plan if need be. Consequences due to criminal behavior will be addressed through the criminal justice entities as DMHAS does not have any legal means to enforce sanctions. Our aim is to partner closely with our criminal justice collaborators in order to positively influence behavior using all available means.

Length of Stay. The length of stay (LOS) will be determined by the needs of the individual. Some individuals might need transitional support (1-3 months), while others may need six to twelve months. The anticipated average LOS is 6 months.

Training. Through the project, five types of training will be offered to *CORP* partners and staff: cultural competence, the subjects to include gender sensitivity and lesbian/gay/bisexual issues; Motivational Enhancement Therapy (MET); the New Hampshire (NH) model of integrated stage-wise treatment (MET is its foundation); Individual Placement and Support (IPS) model; trauma sensitivity; and cross training on mental health and substance abuse treatment, correction, parole, probation, housing, labor/employment issues, and entitlements. Cross training on culturally appropriate, person-centered treatment approaches, integrated substance abuse and mental health treatment, homelessness, gay/bisexual issues, employment services, trauma, HIV/AIDS, resources identification, and other issues that affect the success of the project is essential to the development and coordination of a continuum of services for the target population. The primary goal of the training is to develop professional competence across the wide spectrum of needed services and service providers. Training will be coordinated through the consultation and training services provided by DMHAS' Office of Multicultural Affairs (OMA). OMA's primary mission is to implement multicultural principles, practices, and training throughout the DMHAS system of services and programs and will provide the cultural competence training to increase the ability of the targeted sites to provide services to the target population.

Project staff will also be trained in trauma-sensitive care. Julian Ford, Ph.D., a clinical psychologist with the University of CT Health Center and a widely respected trauma expert, has been working closely with DMHAS in implementing a DMHAS-wide trauma curriculum. Trauma-sensitive mental health and substance abuse treatment includes assistance with identifying life experiences that may have been traumatic, while not pressuring the survivor to disclose those experiences in detail. The therapeutic relationship is non-coercive, non-seductive and non-abandoning. Screening for history of trauma experiences and for trauma disorder symptoms and impairments is done in a careful and respectful manner that is timed to be safe and manageable for the client by building upon the therapeutic relationship.

Evidence-based Approaches: **New Hampshire (NH) Model.** The exemplary integrated approach to substance abuse and mental health treatment developed by the Dartmouth group (the New Hampshire model) has proven to be effective. Drake et al. (1993) have hypothesized that the integrated substance abuse treatment stimulated remission by offering a consistent, longitudinal approach to recovery: every client, even those who were initially denying problems and drinking frequently, became engaged over time in substance abuse treatment. The NH model includes the following summarized components: (1) Integrated treatment. Treatment for co-occurring substance use and

mental health disorders should be concurrent and carefully coordinated (Lehman et al., 1989; Minkoff, 1989; Osher & Kofoed, 1989; Ridgely et al, 1987). (2) Group treatment. Clinicians across a wide variety of programs agree that co-occurring groups of some type are essential treatment components. (3) Phases of treatment. The basic substance abuse treatment paradigm includes four stages: engagement, persuasion, active treatment, and relapse prevention. (4) Substitute activities. Clinicians from a variety of programs agree that clients with co-occurring disorders must develop substitute activities and relationships. These vary greatly across programs but typically emphasize skill building, group identity formation, self-esteem enhancement, and focusing on an abstinent life-style (Teague et al., 1990).

The foundation of the NH Model is Motivational Enhancement Therapy (MET). MET approach encourages the staff to offer non-judgmental support in such a way that develops the client's own motivation to follow through on pragmatic goals. MET, which has been developed to enhance client motivation to change, is based upon principles of cognitive therapy and the client-centered approach of Carl Rogers, with the goal of helping clients to resolve ambivalence and reach a commitment to change (Miller, 1991). It starts with recognition and acceptance of client ambivalence. Proceeding through what may be characterized as a shaping process, this approach attempts to move clients towards acknowledging current problems, developing a desire to change them, and identifying strategies that will enable this change. The clients are engaged in a discussion of problems they have perceived and of concerns that others have voiced, responding to these revelations with empathic feedback that communicates understanding and acceptance. In this way a climate is established in which clients feel safe enough to identify and explore areas of dissatisfaction with their lives.

Work provides the kind of meaningful activity that is at the core of a person's recovery. It is a key part of restoring self-esteem, promoting a positive identity, and providing a meaningful role in the community. The evidence-based **Individual Placement and Support (IPS)** approach integrates vocational services with clinical services to form multidisciplinary teams that provide both clinical and vocational supports. This highly effective recovery-oriented approach: 1) emphasizes what the person prefers for type of job, work hours, setting, and disclosure of disorder; 2) promotes rapid job searches and placements, including the job training if needed; 3) supports competitive employment along with time-unlimited supports; 4) integrates vocational and clinical services in multidisciplinary teams; 5) uses community-based, competitive job settings; and 6) uses a zero-reject eligibility policy. A comparison of three different vocational rehabilitation models demonstrated that persons enrolled in the IPS program had the best outcomes, i.e. highest rates of competitive employment, number of hours worked, and amount of wages earned (Bond et al., 2001).

Phase III: Community-Based Long-Term Support

Plan to Ensure Continuity of Services Between the Institution and the Community. The *CORP* is a comprehensive and integrated system ranging from pre-release outreach and intensive case management through integrated substance abuse and mental health treatment and culminating in assistance with permanent employment and housing. The proposed continuum of care provides multiple points of entry (CT's 18 correctional facilities) and ensures that individuals have immediate access to treatment services and transitional and permanent housing that meets their needs. The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut. Access to services will remain available to participants upon discharge from the active phases of treatment on an as needed basis.

Continuum of Supervision and Services for the Target Population. Scholars and providers agree that our target population has a wide array of complex needs that must be met if treatment is to be successful. Individuals with co-occurring disorders require "a continuum of care" which involves the cooperation of many community-based services. These services range from agencies that offer safe housing to programs that address domestic violence, trauma, and victimization. Essential to the project's success is rallying the support of our key community systems, including coalitions, service providers, faith-based organizations, health professionals, recovery communities, work sites, and neighborhood support groups (Attachment 4-Letters of Support). The planners of the *CORP* assert that it is vital that persons in this program be provided with a broad array of substance abuse, mental health, housing, primary health, economic, vocational, educational, and alternative services that are culturally appropriate and offered in a sustained continuum.

DMHAS, its partners (DOC, Probation, Parole, and WIB), and the proposed community providers (DMHAS' LMHAs) have well-coordinated linkages in place to facilitate client movement from one component to another. Case managers are charged with the responsibility of assuring that individuals are obtaining necessary services and are assisted in locating permanent housing and obtaining employment. Additionally, DMHAS and the proposed community providers offer an array of supports and services within their organizations that can reduce some of the disruption caused by transitions across agencies.

6. Organize Project Management

Oversight of the Connecticut Offender Reentry Project (*CORP)* in developing linkages among substance abuse, mental health, criminal justice, employment, and housing systems will be a collaborative effort drawing on the resources of DMHAS, DOC, Probation, Parole, and WIB. DMHAS, as the Single State Agency (SSA) for substance abuse and mental health services and the applicant, will have primary and lead oversight for the project's implementation and ongoing operation. DMHAS' Local Mental Health Authorities (LMHAs) in Hartford, New Haven, and Bridgeport, will provide the community-based services, including the intensive case management, integrated substance abuse and mental health treatment, employment and housing assistance and supports, aftercare programming, and community-based support services for the target population. Additionally, UConn, through an academic partnership, will provide technical oversight of the intervention strategy and project evaluation.

Existing Resources. Not all needed services for adults released from the state's correctional facilities with co-occurring disorders are available in the targeted areas, and scrutiny of the mental health, substance abuse, employment, and housing systems demonstrates service gaps and needs. *CORP* calls for the expansion and enhancement of intensive case management, mental health and substance abuse treatment, and employment services to be placed in Connecticut's major urban centers (Hartford, New Haven, and Bridgeport), the communities to which the majority of the target populations will return. The proposed provider agencies, CRMHC, CMHC, and GBCMHC, are all state operated units of the DMHAS Healthcare System. Each LMHA provides triage/intake services, case management services, psychosocial rehabilitation services, outpatient services, respite services, homeless outreach, peer support, and a client driven and operated Drop-In Center, in addition to the Assertive Community Treatment (ACT) teams for individuals with co-occurring disorders and a variety of other networks that serve the criminal justice populations with co-occurring disorders. They will keep program participants within their community and involve the entire community in the reintegration of renewed and participating individuals. Additionally, these LMHAs administer the Jail Diversion Programs that provide rapid assessment, triage and clinical services for persons with mental health and/or mental health and substance abuse disorders who become involved with the criminal justice system. The primary goal of this program is to divert from incarceration, those individuals with mental illness who have been charged with low-level offenses by providing treatment options. These programs also increase access to community mental health services; expand judicial options including alternatives to incarceration; enhance public safety; increase the cost-effectiveness of the court, DOC and DMHAS; and provide linkages with mental health staff to facilitate services for individuals entering or exiting corrections.

The LMHAs in Hartford, New Haven, and Bridgeport will expand their capacity to provide intensive case management, integrated mental health and substance abuse treatment services, and vocational and housing supports for 120 (40 annually at each site) men and women released from Connecticut's correctional facilities with co-occurring disorders.

Qualifications and Experience of Key Staff Positions. Adequate staffing is of great importance to the effective implementation of *CORP*. Key positions include Project Director, Project Coordinator, Project Manager, UConn Evaluation Team, Dartmouth Training Team, Case Managers, and Vocational Specialists. Given the proposed demographic characteristics of the target population, recruitment efforts for program staff will ensure appropriate level of cultural competency, with emphasis on bicultural/bilingual candidates.

Gail Sturges, J.D., Project Director (20%FTE, In-Kind). To ensure appropriate oversight of the project, DMHAS' Office of the Commissioner will assign Gail Sturges, Director of Forensic Services, as Project Director. The Project Director will hold primary responsibility for the overall success of the project within the targeted communities, community safety coordination for the target population within the Hartford, New Haven, and Bridgeport service area, and provide supervision and technical assistance to the Project Coordinator.

Ellen Weber, LICSW. Project Coordinator (25% FTE, In-Kind). As Jail Diversion Program Director, Ms. Weber is responsible for the development, implementation, and ongoing monitoring of DMHAS' Jail Diversion Programs in courts across the State. The Project Coordinator will be responsible for the initial phases of the initiative including the planning, designing, and implementation of the project in addition to fostering the collaboration of service providers. The Project Coordinator will work with site staff nad the evaluation team and provide supervision and technical assistance to the Project Manager.

Project Manager (100% FTE, To be hired). The Project Manager will coordinate services across the substance abuse, mental health, criminal justice, employment and housing systems. The Project Manager will work closely with the site staff and the evaluation team to ensure a successful outcome. The Project Manager will need considerable organizational skills and strengths in working closely with state agencies and service providers to accomplish multiple priorities, including developing a training program for project staff and maintain ongoing communication across sites through RSC meetings. It is essential that the individual selected for this position possess experience with serious and violent offender with co-occurring disorders.

Evaluation Study Team. Linda Frisman, Ph.D., the Project Evaluator, will have ultimate responsibility for the design and conduct of the evaluation, and will supervise the Evaluation Coordinator (TBH) and the Data Manager. Dr. Frisman is the Principal

Investigator for four federal Substance Abuse and Mental Health Services Administration (SAMHSA) funded projects: the CMHS Housing Initiative, the Jail Diversion study, the Homeless Families study and Co-occurring Substance Abuse and Trauma Disorder study. The DMHAS Research Division staff are employees of the Psychology Department at the University of CT. The Research Division is committed to hiring persons who are in recovery, and persons of diverse cultural backgrounds.

Dartmouth Training Team. The mission of the New Hampshire Dartmouth Psychiatric Research Center is to promote, facilitate, and evaluate the implementation of evidence-based practices for adults with co-occurring disorders. Dartmouth will provide the training, consultation, and on-site supervision for service providers of *CORP***,** on both the New Hampshire (NH) Model for Integrated Mental Health and Substance Abuse Treatment and the Individual Placement and Support (IPS) vocational model. Dartmouth's masters' level and doctoral level trainers will join with these program practitioners to provide a comprehensive, interdisciplinary approach. Training services shall include ongoing consultation and fidelity measurement.

3 Case Managers (100% FTE, Salary and Support). The case managers (1 in each targeted site) will facilitate service linkages for the integrated substance abuse and mental health treatment and for employment and housing supports services for the target population. The case managers will maintain documentation on each program participant, meet regularly with the *Community Treatment Team* to review cases, and ensure that participants follow through with referred services.

3 Vocational Specialists (100% FTE, Salary and Support). The Vocational Specialists (1 in each targeted site), utilizing the evidence-based Individual Placement and Support (IPS) model, will work collaboratively with the *Community Treatment Team* to integrate vocational services with clinical services to form multidisciplinary teams that provide both clinical and vocational supports. The vocational specialists will: emphasize what the person prefers for type of job, work hours, setting, and disclosure of disorder; promote rapid job searches and placements, including the job training if needed; support competitive employment along with time-unlimited supports; integrate vocational and clinical services in multidisciplinary teams; and use community-based, competitive job settings for individual placements.

Complementary
Applicant Agency Complementing/Matched Funds.

SOURCE	ITEM	AMOUNT
DMHAS-Office of the Commissioner	Project Supervision/Forensic Division	$75,000
Capitol Region Mental Health Center-Hartford	Jail Diversion Program Assertive Community Treatment (ACT) Team PILOTS/Housing Programs	$211,500 $1,467,000 $960,576
Connecticut Mental Health Center-New Haven	Jail Diversion Program Assertive Community Treatment (ACT)	$211,000 $1,445,000

	Team PILOTS/Housing Programs	$961,092
Greater Bridgeport Community Mental Health Center-Bridgeport	Jail Diversion Program Assertive Community Treatment (ACT) Team PILOTS/Housing Programs	$120,500 $1,445,000 $930,668
	TOTAL MATCHED FUNDS	**$7,637,336**

DMHAS and its partners have access to all resources needed to accomplish the project goals over the three-year funded period. The budget includes staff, program funds, and participants' supports needed to deliver the intervention. DMHAS will bear the costs of additional project supervision, training, space, and office equipment.